Nevada State Health Division

Sentinel Event Reporting in Nevada

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Nevada State Health Division

Mandatory Reporting of Sentinel Events

- Incorporated as NRS 439.800-890 by Assembly Bill 1 (AB1), passed during 2002 18th Special Legislative Session
- In response to the Institute of Medicine (IOM) ***To Err Is Human*** and ***Crossing the Quality Chasm*** reports on safe, quality health care systems
- Does not supersede reporting the sentinel event to other regulatory agencies, as required by federal, state and/or local laws
- Regulations codified as NAC 439.900-920
- Nevada Hospital Association (NHA) convened working group, to assist the Health Division with implementation, which is now the NHA Patient Safety Committee
- Mandatory reporting **effective January 1, 2005**

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Additional Legislation

- **Assembly Bill 59 (AB59) passed during 2005 73rd Session of the Nevada Legislature**
  - Amended NRS Chapter 439 with the definition of facility-acquired infection (mirrors CDC definition of nosocomial infection)
  - Amended NRS 439.830 with "unexpected occurrence involving facility-acquired infection" as a reportable sentinel event
  - Effective October 1, 2005

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Additional Legislation (continued)

- **Assembly Bill 206 (AB206) passed during 2009 75th Session of the Nevada Legislature – effective July 1, 2009**
  - Amends various sections of NRS Chapter 439.800-890
    - > Requires each reporting facility to submit an annual report and its patient plan to the Health Division
    - > Transfers the authority to adopt regulations for sentinel event reporting to the State Board of Health
    - > Requires the Health Division to submit an annual sentinel event report to the State Board of Health
    - > Authorizes the Health Division, upon receipt of a report of a sentinel event by a medical facility, to request additional information, conduct an audit or conduct an investigation of the facility
    - > Authorizes the imposition of an administrative sanction to a medical facility that fails to submit a report of a sentinel event, does not have a patient safety plan, or does not have a patient safety committee as required by law

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Additional Legislation (continued)

- **Senate Bill 319 (SB319) passed during 2009 75th Session of the Nevada Legislature – effective July 1, 2009**
  - Strengthens the requirement that a medical facility which reports a sentinel event to conduct an investigation into the cause of the sentinel event and to implement a plan to remedy the cause, i.e., to perform a root cause analysis
  - Requires certain medical facilities to participate in the National Healthcare Safety Network (NHSN) established by the CDC and authorize the Health Division to access the information submitted as part of the NHSN
  - Requires the Health Division to prepare an annual summary of sentinel event reports and post on the state's Quality & Transparency web site
  - Requires the Health Division to analyze and report trends regarding sentinel events, on a quarterly basis
  - Requires the Board of Medical Examiners, the State Board of Nursing and the State Board of Osteopathic Medicine to report to the Health Division any sentinel event identified by the board
  - Requires the Health Division to study the feasibility of tracking and reporting near-miss events as part of the reports of sentinel events and to define the term "near-miss event"

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What facilities must report sentinel events?

NRS 439.805

- Acute Care Hospitals
- Inpatient Psychiatric Centers
- Inpatient Rehabilitation Hospitals
- Ambulatory Surgery Centers
- Independent Centers for Emergency Medical Care
- Obstetric Centers

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What is a sentinel event?
NRS 439.830

An unexpected occurrence involving facility-acquired infection, death or serious physical or psychological injury or the risk thereof, including, without limitation, any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. The term includes loss of limb or function.

- Joint Commission guidance for determining "unexpected occurrence": not related to the natural course of the patient's illness and/or underlying condition
- "CDC Definitions of Nosocomial Infections" acceptable for guidance in identifying reportable facility-acquired infections
- Types based on Joint Commission reportable events, National Quality Forum (NQF) Never Events, and NRS 439.800-890 requirements

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Difference between facility-acquired infection reported as a sentinel event and all other sentinel events:

An unexpected occurrence involving a facility-acquired infection *does not have to result in an adverse outcome or carry the risk thereof*.

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Who is notified about the sentinel event and when?

- Within **24 hours** of identification, the designated **patient safety officer** for the medical facility where the event occurred must be notified (NRS 439.835)
- Within **7 days** of the medical facility receiving notification, **the patient** must be notified of the sentinel event (NRS 439.855)
- Within **13 days*** of the medical facility receiving notification, **Sentinel Event Data Report Section I must be filed with the Nevada State Health Division** (NRS 439.835 and NAC 439.900-920)
- Within **45 days*** of the medical facility receiving notification, **Sentinel Event Data Report Section II must be filed with the Nevada State Health Division** (NRS 439.845 and NAC 439.900-920)

* Based on Joint Commission voluntary reporting guidelines

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What data must be reported?

- Date and time of the event (NRS 439.835 and NAC 439.915)
- Brief description of the event (NRS 439.835 and NAC 439.915)
- Contributing Factors (NRS 439.845 and NAC 439.915)
- Corrective Actions (NRS 439.845 and NAC 439.915)

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Are the sentinel event data reported to the State Health Division confidential?

- All sentinel event data that must be reported are confidential, per NRS 439.840(2) and NRS 439.845
- All sentinel event reports received by the State Health Division, pursuant to NRS 439.800-890 and NAC 439.900-920, are not subject to subpoena or discovery and not subject to inspection by the general public, per NRS 439.840

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Sentinel Event Reporting Mechanics

- **Reporting Forms, Decision Algorithms, and Instruction Guide** available online at: **http://health.nv.gov/Sentinel_Forms_Reports.htm**
- Unique Facility Code provided by the State Health Division to each medical facility required to report – **NO FACILITY NAMES APPEAR ON THE REPORTS**
- Name of the person completing the report, for any questions (entered into the database as a code number)
- Required patient information is minimal – **NO PATIENT NAMES APPEAR ON THE REPORTS**

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Additional Requirements for Reporting Facilities

- **Patient Safety Plan** (NRS 439.865)
- **Patient Safety Officer** (NRS 439.870)
- **Patient Safety Committee** (NRS 439.875 and NAC 439.920)

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VA's National Center for Patient Safety

www.patientsafety.gov/FAQ.html#Products

- **Root Cause Analysis** - www.patientsafety.gov/CogAids/RCA/index.html
  Tips, hints and directions on how to complete an RCA using the NCPS developed analysis process, including Event Flow and Cause and Effect diagramming
- **Triage Cards™** - www.patientsafety.gov/CogAids/Triage/index.html
  The questions RCA teams need to answer when completing RCAs and how to use the 5 Rules of Causation when developing causation statements
- **Healthcare Failure Modes and Effects Analysis™** - www.patientsafety.gov/CogAids/HFMEA/index.html
  Tips, hints, and directions on how to complete a proactive risk assessment using the NCPS developed model

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Sentinel Events Reported
January 1, 2005 – June 30, 2009

2005	2006	2007	2008	2009*	Total
139	188	105	178	75	685

* First six months only

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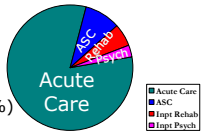
TOTAL Sentinel Events Reported: 685
January 1, 2005 – June 30, 2009

- Acute Care Hospitals – 563 (82%)
- Inpatient Rehab Hospitals – 37 (6%)
- Ambulatory Surgery Centers – 62 (9%)
- Inpatient Psych Hospitals – 23 (3%)



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NEVADA SENTINEL EVENTS REGISTRY
January 1, 2005 – June 30, 2009

TOP 10 REPORTED SENTINEL EVENT TYPES	# Events	% Total
Non-catheter-related Urinary Tract Infection	75	16.13%
Surgical Site Infection	72	15.48%
Fall	56	12.04%
Medication Error*	49	10.54%
Treatment Error (includes 22 incidences of Retained Foreign Object)	47	10.11%
Procedure Complication	44	9.46%
Treatment Delay	40	8.60%
Catheter-related Urinary Tract Infection	36	7.74%
Non-central line-related Blood Stream Infection	29	6.24%
Wrong Site or Surgery Procedure	17	3.66%
Total	**465**	100.00%

* Based on medication error definition from the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP)

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NEVADA SENTINEL EVENTS REGISTRY
January 1, 2005 – June 30, 2009

SENTINEL EVENT OUTCOMES	#EVENTS	% TOTAL
Actual Death	126	18.39%
Risk of Death	55	8.03%
Actual Physical Injury w/Permanent Loss	48	7.01%
Actual Physical & Psychological Injury w/Permanent Loss	6	0.88%
Risk of Physical Injury w/Permanent Loss	185	27.01%
Risk of Psychological Injury w/Permanent Loss	22	3.21%
Actual Infection – No Adverse Outcome or Risk Thereof	243	35.47%
TOTAL	**685**	**100%**

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NEVADA SENTINEL EVENTS REGISTRY
January 1, 2005 – June 30, 2009

SENTINEL EVENT DEMOGRAPHICS	NUMBER	%TOTAL
By Age		
< 1 year	34	4.96%
1 year to 19 years	20	2.92%
20 years to 64 years	271	39.56%
65 years and older	360	52.56%
By Gender		
Female	422	61.61%
Male	263	38.39%

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Typical Sentinel Event Patient Profile:
Non-Infection

- **Who:** Female, 65+ y/o
- **Where:** Medical/Surgical Unit of an Acute Care Hospital
- **Sentinel Event:** Medication Error
- **Contributing Factors:** Failure to Follow Policy/Procedure and Poor Communication or Handoff
- **Outcome:** Risk of Physical Injury, w/Permanent Loss
- **Corrective Actions:** Staff Education, Policy/Procedure/ Process Review, and Policy/Procedure/Process Modification

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Typical Sentinel Event Patient Profile:
Nosocomial Infection

- **Who:** Frail, Unsteady Female, 80-89 y/o
- **Where:** Long Term Care Unit of an Acute Care Hospital
- **Sentinel Event:** Non-catheter related UTI
- **Contributing Factors:** Failure to Follow Policy/Procedure and Poor Communication or Handoff
- **Outcome:** Actual Sentinel Event, with No Adverse Outcome or Risk of Adverse Outcome
- **Corrective Actions:** Staff Education, Policy/Procedure/ Process Review, and Policy/Procedure/Process Modification